Model 2002 EOC
Cost Plan Reference Guide

This reference guide is intended to aid 1876 cost plans in the development of their 2002 EOCs. The guide indicates those sections of the 2002 model EOC that need to be changed to accommodate cost plan rules.

- Column 1, "Model EOC Section/Subsection" is based on the sections and subsections contained in the 2002 model EOC.
- Column 2, "Need Change?" indicates whether a change would be needed to the cost plan EOC ("Yes" means a change is necessary).
- Column 3, "If yes, what changes are needed?" outlines what change is needed if Column 2 contains a "Yes."

Note: This Reference Guide does not indicate all places in the model in which reference to "Medicare+Choice" needs to be changed to "Medicare managed care." Cost plans should make changes as needed.

Model EOC Section/Subsection	Need Change?	If yes, what changes are needed?
Reference Page	No	
Welcome Letter	No	
Section 1: Reference Page of phone numbers and addresses	No	
Section 2: Getting started as a member of {plan}		
What it means to be in a managed care plan	Yes	Second paragraph 1. Modify to indicate that staying within the plan provider network will result in plan benefits, and going outside of the network, except for emergencies and urgent care, will result in member responsibility for Original Medicare deductibles and coinsurance. 2. Reference to out-of-area renal dialysis services is inappropriate for Cost Plans.
Your membership card	Yes	Replace paragraph to state "Use your red, white, and blue Medicare card when you want to receive services not covered by *[name of cost plan]* from non-plan providers."
Section 3: Getting the care you need, including some rules you must follow		
Plan service area	No	
Using plan providers to get your care	No	

Model EOC Section/Subsection	Need Change?	If yes, what changes are needed?
Your PCP will coordinate all of your care	Yes	1. "Lock-in" - Modify for in-network vs. out-of-network benefit – specify that members can access benefits from any Medicare providers. 2. Delete narrative in third paragraph that explains that the MCO receives a fixed monthly dollar amount for each members it serves.
Getting care from your PCP	No	
Getting care from specialists	Yes	Under "please note the following" - Explain that going outside of the network for Specialist care will result in coverage under Original Medicare.
There are some services you can get on your own without a referral	Yes	Cost plans only need cover flu shots without a referral, they are permitted to delete "pneumococcal vaccinations" in the first bullet. Finally, cost plans only need cover mammograms without a referral, they are permitted to delete "pap tests, pelvic and breast exams" in the second bullet.
Changing doctors	No	
The doctor-patient relationship	No	
Getting care when you travel or are away from the service area	Yes	90-day out of area rule; Member retention for up to one year is permitted - 42 CFR 417.460(f)(2). Cost plan should explain its policy. Plus explain that going outside of the network for non-routine care, except for emergencies and urgent care will result in coverage under Original Medicare. Delete any reference to out of area renal dialysis.
Section 4: Getting care in an emergency or when you have an urgent need for care		
Getting care if you have an emergency	Yes	1. Post-stabilization services from non-plan providers not applicable; 2. Coverage for renal dialysis when out-of-area not applicable, and would be covered under Original Medicare. 3. Cost plans should use 417.401 definition of emergency services. 4. Delete definition of "emergency medical condition."
Getting care if you have an urgent need for care	Yes	1. 90-day rule should be substituted for 6-month rule. Member retention for up to one year is permitted - 42 CFR 417.460(f)(2). Cost plan should explain its policy. Plus explain that going out of the area for routine or elective medical services will result in coverage under Original Medicare. 2. Cost plans should use 417.401 definition of urgently needed services.
Section 5: Your coverage – the medical benefits and services you get as a member of {plan}		
Introduction to your medical care benefits and services	Yes	1. Under "Can benefits change?" Cost plans send notice of changes in November; 2. Definition of "covered services" - Post stabilization, 1-hour requirement, and renal dialysis services provisions are inappropriate for Cost Plans.

Model EOC Section/Subsection	Need Change?	If yes, what changes are needed?
Schedule of Medical benefits	Yes	1. Pap Tests - Self referral not required 2. Pneumococcal shots - Self referral not required 3.Cost plans may delete all benefit categories that describe non-Medicare covered services
How you can purchase extra benefits	Yes	1. Only include if applicable. 2. Delete statements that optional supplemental benefits are subject to same appeals process as other benefits.
Section 6: Using your coverage for prescription medicines	No	(If applicable)
Section 7: Using your coverage for hospital care, care in a SNF, and other services	Yes	1. Billing option 1 cost plans may need to modify language wherever payment is discussed, to be sure it is clear that Original Medicare (not the plan) would pay for the member's covered stay. (For example, under "using your coverage for hospital care," the note about coverage beginning when the member was an inpatient may need to be modified.) 2. Home SNF benefit does not apply (M+C benefit only)
Section 8: Medicare care and services that are not covered	No	
Section 9: What you must pay for your Medicare health plan coverage and for the care you receive		
A summary of your financial obligations	Yes	Revise bullet #5 to reflect plan policy for Part B-only enrollees purchasing Equivalent Part A benefits.
Paying the premium for your health plan coverage as a member of {plan}	Yes	1. Nonpayment of premiums requires the notice of disenrollment date to be 20 days prior to the termination date 2. Notification of plan changes occurs in November. 3. Remove references to 90-day grace period for nonpayment of premiums.
Paying for Medicare Part A and Part B	Yes	1. May retain discussion of paying Part A premium, but language should not imply you have to keep paying to be a member. 2. For Part A coverage, the cost plan may state that when applicable, the member must pay/continue to pay Part A equivalent premiums.
Co-payments, and other charges you must pay when you get care	No	
You must pay for all care and services that are not covered by Medicare or {plan}	Yes	Delete reference to out-of-area renal dialysis services.
What happens if you have other insurance	No	

Model EOC Section/Subsection	Need Change?	If yes, what changes are needed?
How we pay the doctors and other providers who take care of you	Yes	Billing option 1 cost plans delete reference that it is MCO's responsibility to pay providers' charges for covered benefits for hospital and Part A services. Instead, note that under some circumstances, payment may be made to the provider directly by Original Medicare.
What if you pay for care yourself, or you are billed for services?	Yes	1. Delete reference to out-of-area renal dialysis services. 2. Modify second paragraph to more clearly state plan's policy with respect to payment for non-contracting providers (Cost plans are permitted to require billing to Original Medicare for non-contracting providers. Cost plans then pay applicable deductibles/copays on member's behalf.)
Section 10: Appeals and Grievances: what to do if you have concerns or complaints		
Complaints related to your coverage, including payment for care	No	
What to do if you think that coverage of your hospital stay is ending too soon	Yes	For cost plans electing billing option 1 [42 CFR 417.532(c)], language needs to be modified to show that it is the Original Medicare Fiscal Intermediary that is responsible for processing hospital-discharge appeals that are not processed by the PRO. (In other words, for inpatient hospital and SNF appeals, since the cost plan that has elected billing option 1 relies on Original Medicare to pay the claim, it needs to be made clear that any disputes related to that claim payment should be directed to the FI that has responsibility for payment)
Making complaints ("filing grievances") about all other types of problems	No	
Section 11: Disenrollment: leaving {plan}, and your choices for continuing Medicare after you leave		
What is "disenrollment"?	Yes	Delete mention of election limits on when/how often can leave plan (disenrollment is continuous for cost plans)
Explain that the member must use plan providers until the disenrollment date	Yes	Explain that going outside of the plan, except for emergencies and urgent care, for care prior to the date of disenrollment will result in coverage under Original Medicare.
What are your choices for continuing Medicare if you leave (plan)?	No	

Model EOC Section/Subsection	Need Change?	If yes, what changes are needed?
When and how often can you switch among your Medicare choices?	Yes	Entire section on "A new law about when and how often you can switch" not applicable. Disenrollment is continuous for cost plans. However, cost plans may want to note that there are some limits on when disenrollees will be able to subsequently join an M+C or PFFS plan. Cost plans may refer disenrollees to 1-800-MEDICARE for more information on election limits.
What should you do if you decide to leave (plan)	Yes	Delete references to needing to make sure timing of change fits new rules
How to change from (plan) to Original Medicare	Yes	1. Effective date will be first of the following month after receipt of request, but no later than 3 months after receipt. 2. Revise language in item #3 to state that upon disenrollment the former member should use his/her red, white, and blue Medicare card for all services.
How to change from (plan) to another Medicare managed care plan or PFFS	Yes	1. Need to point out that other Medicare managed care plans and PFFS are only available (open for enrollment) during certain times of the year. Can refer member to 1-800-MEDICARE to find out when these plans are open. 2. In second numbered paragraph, revise language to be clear that the member msut continue to get medical care through the cost plan to be eligible for plan benefits.
What happens to you if (MCO) leaves the Medicare program or (plan) leaves the area where you live?	Yes	Cost plans have 60 days to give notice to members (not 90)
What if you move out of (plan) service area or are away from the service area for long periods of time?	Yes	1. Change reference to 6-month rule to reference to 90-day out of area rule 2. Member retention for up to one year is permitted - 42 CFR 417.460(f)(2). Cost plan should explain its policy. Plus explain that going outside of the network for Nonroutine care, except for emergencies and urgent care will result in coverage under Original Medicare.
Under certain conditions (plan) can end your membership and make you leave the plan	Yes	1. Change reference to 6-month rule to reference to 90-day out of area rule. 2. Member retention for up to one year is permitted - 42 CFR 417.460(f)(2). Cost plan should explain its policy. Plus explain that going outside of the network for Nonroutine care, except for emergencies and urgent care will result in coverage under Original Medicare; 3. Bullet 1, delete "both Medicare Part A and" 4. Bullet 5, nonpayment of premiums requires the notice of disenrollment date be 20 days prior to the termination date. Also, delete reference to 90-day grace period.
You have the right to make a complaint if we ask you to leave (plan)	No	
What if you are told you must leave (plan) and you feel it is because of your health?	No	

Model EOC Section/Subsection	Need Change?	If yes, what changes are needed?
Appendix A: Reference list of important words used in this booklet	Yes	1. Definition of "M+C organization" and "M+C plan" not applicable (instead, insert a definition for "cost plan"; 2. Modify "Lock-in" definition for in-network vs. out-of-network benefit – specify that members can access benefits from any Medicare provider; 3. Re: definition of "covered services" - reference to post stabilization, and renal dialysis services provisions inappropriate for cost plans 4. Re: definition of "urgently needed services" – delete last sentence. Also, delete "ordinarily" in preceding sentence.
Appendix B: More information about the appeals process	Yes	General: 1. Modify appendix by substituting any stricter State requirements that do not serve as obstacle to meeting obligations under Federal regulations. 2. Delete references to optional supplemental benefits being subject to appeals rules.
Step 1 – Step 2	Yes	Time frames are different: 60-day w/no extensions for standard initial decisions (service and payment); 60-day w/no extensions for standard appeal; 72 hours with up to 10-working day extension allowed for expedited reviews Time frames for effectuation dates are based on medical necessity or within 30 days.
Step 3	Yes	CHDR time frames are different: 60-day timeframe for service and payment; Provision of service/payment after overturn: as soon as medically necessary but no later than 30 days.
Step 4	No	
Step 5	No	
Step 6	No	
Appendix C: Legal Notices	No	
Appendix D: Information about Advance Directives	No	